FAX: 844-236-0933
E-mail: Disabled_dep_@uhc.com

Disabled Dependent Child Certification

Completing the Disabled Dependent Child Certification

Completion of this certification is required for dependents that are coming upon the limiting age and need benefits to continue due to a physical or mental disability. To determine if your dependent qualifies for the Disabled Dependent Benefit, completion of this form by the employee and treating medical provider is required.

Instructions

1. **Employee Statement Pages:** Sections I, II, III, and IV to be completed in their entirety by the employee. **Employee** is required to sign and date in Section IV. Employee Confirmation, Signature and Date.

2. Employee to provide an Active/Current copy of the "order/s" (*guardianship, conservatorship, court order, divorce decree)* employee has in place for the dependent if circled in Section II, Dependent Information and/or an Active/Current copy of the SSDI/SSI Benefit Statement if "Yes" was circled in Section III, Question 5.

3. Employee to provide a copy of the proof of prior coverage documents, **IF**, '**YES**' was circled in Section III, Question 2 - "Did the dependent have a loss of coverage?"

4. **Medical Provider Statement Page:** To be completed in its entirety by the treating medical provider. **Treating medical provider** is required to confirm, sign and date.

5. Confirm all pages of the certification form have been completed in their entirety **AND** make a copy for your files before returning the form. *(omission of any information required will cause a delay in the processing of your request)*

6. Return all pages of the fully completed certification form and any additional documents to UnitedHealthcare at the email address or fax number shown below:

   Dependent Disability Dept.
   Email: disabled_dep_@uhc.com
   or
   Fax: 844-236-0933

Upon completion of the review process, you and/or your employer group will receive a letter advising of the review determination and coverage dates if applicable. Please allow up to 30 business days for review completion.

For any additional questions regarding your dependent child's eligibility benefits, please contact your employer's Human Resources Department for further assistance.

United Healthcare

Disabled Dependent Child Certification

FAX: 844-236-0933
E-mail: Disabled_dep_@uhc.com

Employee's Statement

Employee to complete Sections I, II, III & IV. Omitted information will cause delays.

Section I. Employee Information

Group Number	Group Name

PRINT Name: (First, Middle, Last)

Marital Status (Circle One) Never Married Married Divorced Widowed Legally Separated

Date of Birth	Member/Subscriber ID#	Relationship to Dependent	Phone: (Including Area Code)
/ /			( )

Current Address(es) (Street, City, State, Zip Code)

Physical:

Mailing:

Email:

Section II. Dependent Information

Refer to your Member Handbook for who qualifies as an eligible dependent.

Circle **all applicable** orders in place by Employee regarding Dependent. Guardianship Court Order
If circled, **submit an Active/Current copy** of each with this form. Conservatorship Divorce Decree

PRINT Name: (First, Middle, Last) | Date of Birth / /

Marital Status (Circle One) Never Married Married Divorced Widowed Legally Separated

Does the Dependent reside in your household? (Circle one) **NO / YES**

If **NO**, provide reason for different residing address than employee below. (Example: Lives in a group home, medical facility, etc.)

Currently Resides at: (Street, City, State, Zip Code)

Physical:

Mailing:

Section III. Financial and Dependent Employment Information

For Employees with a New Employer:

1. Was dependent covered under your prior Employer's Insurance Plan? (Circle One) **NO / YES / Not Applicable**

1a. If **YES**, provide Coverage dates. From: _____/_____/_____ To: _____/_____/_____

1b. If **NO**, please explain.

2. Did the dependent have a loss of coverage? (Circle One) **NO / YES / Not Applicable**

2a. If **YES**, Submit a copy / proof of prior coverage AND answer coverage questions below:

Prior Insurance Carrier:

Subscriber's name:

Group Name:

Coverage dates: From: _____/_____/_____ To: _____/_____/_____

3. Does employee provide more than 50% of the dependent's support & maintenance*? (Circle One) **NO / YES**

*For example: food, medicine/prescriptions, utility, housing, etc.

Continue to Next Page

United Healthcare

FAX: 844-236-0933
E-mail: Disabled_dep_@uhc.com

Disabled Dependent Child Certification

Section III. Financial and Dependent Employment Information (Continued)

4. On what date was the dependent last claimed on your Federal Personal Income Tax Return? Date Last Claimed: ____/____/_____

4a. Provide further explanation below.

5. Does dependent receive SSDI/SSI benefits? (Circle one) **NO / YES**

5a. If YES, Amount per Month $_____, **AND** submit a copy of current SSDI/SSI Benefit Statement.

6. Is dependent currently working? (Circle One) Full Time / Part Time / Currently Not Working

6a. If dependent is NOT currently working, Date Last Employed: _____/_____/_____

6b. If dependent is currently working, Gross Monthly Income (before taxes) $_____

6c. Is dependent's current position with employer eligible for health insurance? (Circle One) **NO / YES**

6c-1. If answered YES, above in **6c**, Is dependent carrying "own" health insurance? (Circle one) **NO / YES**

6c-1a. If answered NO, above in **6c-1**, provide explanation as to why dependent is not carrying "own" coverage.

6d. Provide Name and address of dependent's current employer below: (Street, City, State, Zip Code)

7. Is dependent currently a student in post-secondary schooling? (Circle one) **NO / YES**

7a. What is the highest grade/level of schooling completed?

Enrolled: (Circle one) **Full-Time / Part-Time** Grade/Level: _____ School type: _____

8. Does dependent hold a valid drivers license? (Circle One) **NO / YES**

9. Provide any further Explanations/Additional Information: (attach additional pages if needed)

Section IV. Employee Confirmation, Signature and Date

I confirm I have completed the Employee's Statement in it's entirety. I know it is a crime to fill out this form with information I know is false or leave out information I know is important.

Employee Signature: _____ **Date:** _____/_____/_____

For processing purposes, Employee's Statement and Medical Provider Statement MUST be submitted together.

Disabled Dependent Child Certification

FAX: 844-236-0933
E-mail: Disabled_dep_@uhc.com

THIS PAGE IS TO BE COMPLETED IN FULL BY THE DEPENDENT'S TREATING MEDICAL PROVIDER ONLY.

Medical Provider Statement

(Any fee for the completion of this statement is to be paid by the employee.)
Answer all questions below. Omitted information will cause delays.

Patient 's Name: (First, Middle, Last)	**Patient's Date of Birth** / /

1. What is the primary disabling diagnosis?

2. Age diagnosed with Primary Disabling Diagnosis? (Circle One) From Birth / From _____ Years of Age

3. The patient is presently: (Circle all applicable) Ambulatory **Confined To:** Bed House Hospital Wheelchair

4. What are the physical/mental/functional limitations related to the primary disabling diagnosis?

5. Are there any other diagnoses currently being treated? (Circle One) **NO / YES**

5a. If YES, please list:

6. Is patient currently able to work? (Circle One) **NO / YES**	**6a.** If **YES**, (Circle One) **Full Time / Part Time**

7. Is patient currently able to be self-supportive [does not need financial help from others]**?** (Circle One) **NO / YES**

7a. Is patient currently physically able to care for self? (Circle One) **NO / YES**

8. Will patient be capable of self-support in the future? (Circle One) **NO / YES** **If Yes, as of What Date:** _____/_____/_____

9. If you answered NO to Questions 6-8 above. Please explain below. (circle all applicable)

Intellectual/Developmental Disability **Physical Handicap** **Mental Handicap** **Other** (Explain below)

☐ **Documents Attached. Current written documentation or medical records (within the last three (3) months).**

I confirm I have completed the Medical Provider Statement in it's entirety. I know it is a crime to fill out this form with information I know is false or to leave out information I know is important.

Medical Provider Signature: _____ **Date:** _____/_____/_____

PRINT Medical Provider Name, Address (Street, City, State, Zip Code)	Phone: (Including Area Code) ( )

For processing purposes, Employee's Statement and Medical Provider Statement MUST be submitted together.